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Nos. 96-110 and 95-1858

In The

Supreme Court of the United States

October Term, 1996

STATE OF WASHINGTON, *et al.*,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

DENNIS C. VACCO, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari
To The United States Courts Of Appeals
For The Ninth And Second Circuits

BRIEF OF AMICUS CURIAE RICHARD THOMPSON OAKLAND COUNTY PROSECUTING ATTORNEY IN SUPPORT OF PETITIONERS

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45 pp

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES:

CONSTITUTIONAL AND STATUTORY AUTHORITY:

MISCELLANEOUS:

TABLE OF AUTHORITIES – Continued

Page

TABLE OF AUTHORITIES – Continued

INTEREST OF THE AMICUS[1]

The Court of Appeals for the Ninth Circuit has discovered a constitutionally-protected liberty interest to medical assistance for a competent, terminally-ill, adult person who has chosen to commit suicide. This liberty interest is claimed as a component of the due process clause of the Fourteenth Amendment. The Court of Appeals for the Second Circuit has rejected this new constitutional right based on due process, but has held that a statute which precludes willing physicians from prescribing drugs to competent terminally-ill adults who wish to end their lives using these drugs violates the equal protection clause of the Fourteenth Amendment. U. S. CONST. amend XIV, § 1.

Petitioner State of Washington will explain how the Ninth Circuit erred in announcing a new constitutional right grounded in due process. Petitioner Vacco will explain how the Second Circuit erred in finding a violation of the equal protection clause. Numerous other amici will address associated concerns implicated by recognition of a new constitutional right to so-called physician-assisted suicide, or the "right to die with assistance."[2]

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[1] Letters of consent have been sent to the Clerk of the Court pursuant to Rule 37.3.

[2] Following the modern tenet that the first step in gaining public support for an idea is to identify the concept in the most positive manner, supporters of physician-assisted suicide generally identify the issue as "the right to choose the manner and time of one's death" or "the right of terminally-ill competent adults who are suffering unremitting and unremediable pain to choose when and how to end their suffering." In other words, they try to use a label which invokes a right to personal autonomy (*i.e.*, the "right to choose"). However, just as "a rose by any other name is still a rose,"

For example, the American Medical Association will be able to advise this Court of the impact on the medical profession which will result from recognition of a new constitutional right to die with physician assistance. Such a right would initiate a change in the traditional role of doctors as healers who are ethically sworn to "do no harm."

Moreover, in this day of escalating medical costs, debate over a national health care system, constant medical advances aimed toward prolonging life, and an aging population, there will inexorably be pressure on doctors, nurses, and relatives of terminally-ill patients to cut short nature's course. The patients themselves will also feel pressure to end their lives to save often scarce and limited family financial resources and to avoid being a burden on their loved ones.

Advocates for the physically or mentally disabled will be able to advise this Court of the pressure that recognition of such a right will put on disabled persons, who all too often are already marginalized or ignored by society.

Medical ethicists can inform this Court, as Daniel Callahan has written, that

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euthanasia by any other name is still euthanasia. In Y. Kamisar, *Physician-assisted suicide: the last bridge to active voluntary euthanasia*, in Euthanasia Examined (J. Keown ed. 1995), Professor Yale Kamisar observes at page 225: "Some 30 years ago an eminent constitutional law scholar, Charles L. Black, Jr., spoke of 'toiling uphill against that heaviest of all argumental weights – the weight of a slogan.' I am reminded of that observation when I confront the slogan the 'right to die.' Few rallying cries or slogans are more appealing and seductive than the 'right to die.' But few are more fuzzy, more misleading, or more misunderstood."

> [t]he proposal to legalize euthanasia and assisted suicide is nothing less than a proposal to add a new category of acceptable killing to those already socially legitimated. To do so would be to reverse the long-developing trend to limit the occasions of legally sanctioned killing (most notable in the campaigns to abolish capital punishment and to limit access to handguns). Civilized societies have slowly come to understand how virtually impossible it is to control even legally sanctioned killing. No matter how carefully safeguards are fashioned, abuse and corruption are invited.

D. Callahan, *The Troubled Dream of Life* (1993), pp 104-105.

Review of this Court's own writings will alert the Court that recognition of a new constitutional right to assisted suicide will start an inexorable process of enlargement of that initially limited and narrowly-defined right. As this Court stated in *United States v 12 200-ft Reels of Super 8mm Film*, 413 U.S. 123, 127 (1973):

> * * * The seductive plausibility of single steps in a chain of evolutionary development of a legal rule is often not perceived until a third, fourth, or fifth "logical" extension occurs. Each step, when taken, appeared a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance. This kind of gestative propensity calls for the "line drawing" familiar in the judicial, as in the legislative process: "this far but not beyond." * * * .

This Court also recognized this "seductive plausibility of single steps in a chain" in *Boyd v United States*, 116 U.S. 616, 635 (1886). Justice Bradley, writing for the majority, in response to the government's argument that compelling the defendants to turn over an invoice was an

inconsequential matter that didn't really implicate search and seizure concerns, cautioned:

> It may be that it is the obnoxious thing in its mildest and least repulsive form; but illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure. . . . [The Courts'] motto should be *obsta principiis*.

Or, as Professor Kamisar has observed in Y. Kamisar, *When is there a Constitutional "Right to die"? When is there No Constitutional "Right to live"?*, 25 Georgia L Rev 1203, 1227 (1991):

> However, what we cannot do – perhaps cannot even think about doing – in one step we are often able to do in two or three. Professor Schneider has called this "a psychological aspect of slippery slopes: they work partly by domesticating one idea [say, disconnecting the respirator] and thus making its nearest neighbor down the slope seem less extreme and unthinkable." [Footnote omitted.]

Both petitioners and amici can inform the Court of the certainty that recognition of a new constitutional right will inevitably start our society on a trip down that "slippery slope" by cutting off public debate, divesting the legislature of its power to regulate this question, putting the government's imprimatur of approval behind the broad concept of assisted suicide, and thus further acclimatizing the citizenry to the acceptability of that idea and thereby preparing them for further steps down the perilous slope.

However, only one amicus can address this Honorable Court from actual practical experience with the reality of assisted suicide: the Prosecutor of the County of Oakland who has attempted to prosecute the "poster

child" of the assisted suicide movement, Jack Kevorkian, for his role in the deaths of five individuals.

Altogether, by present count (the figure changes virtually day-to-day), Kevorkian has acknowledged being present at the suicides of 45 people. His attorney has further admitted that Kevorkian has assisted some undisclosed number of other "patients" to commit suicide. The majority of these deaths have occurred in Oakland County. Kevorkian resides in, and provides his suicide assistance, mainly in Oakland County. On October 29, 1996, Amicus petitioned for, and obtained, an order to show cause why Kevorkian should not be held in contempt for his alleged continuing violations of a permanent injunction issued by the Oakland County Circuit Court in 1991.[3] On October 31, 1996, Amicus filed new criminal charges against Kevorkian and his associates covering such activities as assisting in suicides, conspiracy, removing dead bodies without the permission of the medical examiner, holding himself out as a practicing physician while engaging in unlawful conduct, and possession of a controlled substance. Thus whatever decision this Honorable Court renders will have its greatest and most immediate impact on the Oakland County Prosecutor's Office.

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[3] This injunction was upheld by the Michigan Court of Appeals, leave to appeal has been denied by the Michigan Supreme Court, and on October 15, 1996, the United States Supreme Court denied Kevorkian's petition for writ of certiorari. *People ex rel Oakland County Prosecuting Attorney v Kevorkian*, 210 Mich. App. 601; 534 N.W.2d 172 (1995), lv. den. 451 Mich. 874; 549 N.W.2d 566 (1996), cert. den. ___ U.S. ___ (No. 96-135; Oct. 15, 1996)

SUMMARY OF ARGUMENT

The on-going campaign by Jack Kevorkian over the past six years to gain recognition for his right to assist people of his choosing to commit suicide has focused national attention on the issue of assisted suicide. Advocates of the practice have insisted that, despite overwhelming historical evidence to the contrary, assisted suicide is a constitutionally-protected right. Those opposed to the recognition of a new constitutional right have pointed not only to the historical and legal record, but also to concerns regarding inevitable abuses which will occur if this Court creates such a new constitutional right.

Amicus submits that the actions of Kevorkian in Oakland County, Michigan, clearly demonstrate that the fears of the opponents of assisted suicide are valid. In fact, virtually all of the arguments against assisted suicide can be illustrated by examination of the "patients" who have chosen to submit their lives to Kevorkian's care.

Kevorkian assists others to commit suicide based solely upon his own determination of whether their request for his assistance is rational. He does not require that they be terminally ill or in unremitting and unremediable pain. He requires only that they suffer from some real or imagined malady that has sufficiently interfered with their "quality of life" as to convince them that their life is not worth living. If they are able to make a request for his assistance in what appears to him to be a competent manner, then Kevorkian is all too ready to grant that request. He engages in a facade of performing a medical procedure with adequate safety checks, but in reality if his subjects are willing to have him assist them to commit suicide, then they invariably receive his assistance and

they die – whatever their true physical and mental condition.

Only by refusing to recognize a new constitutional right to die can this Court hope to prevent an incursion of more "Dr. Deaths" who will offer the sick, infirm, depressed, and aged only the siren song of a painless death.

ARGUMENT

THIS COURT SHOULD NOT RECOGNIZE A NEW CONSTITUTIONAL RIGHT TO DIE WITH THE ASSISTANCE OF A PHYSICIAN UNDER EITHER THE DUE PROCESS CLAUSE OR THE EQUAL PROTECTION CLAUSE WHERE SUCH A RIGHT IS NOT MENTIONED IN THE CONSTITUTION, HAS NO SUPPORT IN THE LEGAL HISTORY OF THIS NATION, IS NOT RECOGNIZED BY THE LAWS OF THE 50 STATES, AND IS INCAPABLE OF BEING CONFINED OR CONTROLLED BY SPECIFIC JUDICIAL OR LEGISLATIVE REGULATIONS.

In the person and practice of Kevorkian this Court can see revealed virtually all of the ills which inevitably afflict the concept of assisted suicide.

Supporters of assisted suicide claim that it would only be utilized by mentally competent adults who were terminally ill and/or suffering great and unremediable pain. Both the Ninth and Second Circuits have affirmed this supposedly "narrow" recognition of a new constitutional right.

Yet given the amorphous nature of the concepts of "terminal" illness and "pain," in actual practice the right could never be restricted only to the terminally ill who were suffering great pain. While some might view terminal illness as a sickness that is sure to kill within days, for

others terminal illness is simply a diagnosis that indicates to some degree of medical certainty that the person afflicted will inevitably die as a direct result of the disease – be it days, weeks, months, or years later. Similarly, what is great and unremitting pain to one person is a level of pain that can be stoically borne by another.

In actual practice such a new constitutional right could *never* be narrowly restricted. The experience amicus has had with Kevorkian bears this out.

In his book, *Prescription: Medicide – The Goodness of Planned Death* (1991), Kevorkian recalls discussing the possible use of his new invention, the "Mercitron" (an intravenous poison drip apparatus), with a potential initial recipient of his services:

> I had to make the patient understand why she was not a suitable candidate for the first use of the Mercitron. Even though she was terribly agonized by an intolerable "quality of life," her condition was not imminently terminal. In order to minimize the passionate (if irrational) storm of criticism certain to be evoked by such a procedure, I realized that ideally it should be in connection with a suffering and indisputably terminal patient – for example, someone dying of incurable and widespread cancer. I explained how that should blunt condemnation of my assisting her as the second case. * * * . [*Id.* at p 219.]

This woman eventually ceased contact with Kevorkian. However, subsequent events demonstrated that Kevorkian had set aside his fears of an "irrational storm of criticism" because none of his first three "test subjects" were terminally ill.

The first woman to meet her death with Kevorkian's active assistance was Janet Adkins, a 54-year-old wife and mother from Portland, Oregon, who was in the early

stages of Alzheimer's disease. She had no physical pain; indeed, she played tennis shortly before she traveled to Michigan to seek Kevorkian's aid in committing suicide. The plain evidence, supported by the autopsy, conclusively demonstrated that she could not even remotely have been considered terminally-ill or suffering from unremitting and intractable pain. In an interview conducted with Adkins before her death, Kevorkian himself states to Adkins' husband (in Adkins' presence): "Of course you realize that she is not terminal." M. Betzold, *Appointment with Dr. Death*, (1993) at p 70. In response to Kevorkian's question, Janet Adkins admitted that she was not in pain. *Id.* at 69. Kevorkian acknowledged in a deposition taken on July 25, 1990, that he personally met Mrs. Adkins for the first time on June 2, 1990. (Tr. of deposition, p 13; App. 5-6) He interviewed her for approximately 40 minutes (while he video-taped the proceeding for posterity) and concluded that "there was enough evidence that she was mentally sound. She knew what she was doing." (Tr. of deposition, p 18; App. 6) Kevorkian admitted he did not physically examine Adkins and merely reviewed medical records that were almost a year old. (Tr. of deposition, pp 24-25; App. 6-7) When asked if Adkins might have been suffering from depression, Kevorkian responded: "Not to be depressed with Alzheimer's is abnormal."[4] (Tr. of deposition, p 27;

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[4] In his testimony before Circuit Judge Alice L. Gilbert in a case seeking a civil injunction, Dr. Kevorkian made the same assertion. When asked whether it was important for him to be able to recognize suicidal ideation in those he evaluated, Kevorkian responded: "Not if they have a crippling physical disease. I don't rely on mental problems. I rely on their physical disease, which then affects the mind. Anybody who's got a terrible crippling disease or terminal cancer and is not depressed is abnormal." (Tr. of June 8, 1990, pp 43-44; App. 3)

App. 7) On June 4, 1990, in the back of his rusty 1968 Volkswagen camper, Kevorkian attached his suicide apparatus to Mrs. Adkins' arm and stood by while she started a flow of poison into her body.

The second woman to whom Kevorkian provided his "services" was Sherry Miller, a 43-year-old woman who resided in Roseville, Michigan. Ms. Miller had multiple sclerosis, but was not terminally-ill and was not suffering physical pain. Dr. Ljubisa J. Dragovic, the Chief Medical Examiner for Oakland County, testified at the preliminary examination of Kevorkian (on charges arising from the deaths of Miller and Marjorie Wantz), that Miller was not in danger of imminent death as a result of multiple sclerosis, that the disease had not yet affected her heart, lungs, or gastrointestinal system, and that, considering the quality of her internal organs, "she had good chances of relatively long survival." (Tr. of February 15, 1992, 326-327; see App. 8-9) She had simply become tired of trying to cope with her diminishing physical ability, and, since she was single, did not want to burden others with her care.[5]

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[5] Sherry Miller testified at a proceeding in the Oakland County Circuit Court wherein the amicus sought (and ultimately obtained) an injunction against Kevorkian providing any assistance to individuals seeking to commit suicide. She repeatedly stated that she desired to commit suicide because she didn't want to be a burden to her family. For example, in response to questioning from Kevorkian's attorney concerning whether she felt she had a responsibility to her parents to remain alive, Ms. Miller responded: " . . . I don't think that's fair because I have to burden my parents with the responsibility of taking care of me. [I'm] Forty-two years old. They're getting older. No, it's not fair." (Oakland County Circuit Court case no. 90-390963 AZ, Tr. of January 8, 1991, p 155 – see App. 7-8.) Subsequently, when asked by the prosecutor when she first

The third woman Kevorkian assisted was Marjorie Wantz, a 58-year-old woman from Sodus, Michigan. Mrs. Wantz claimed to have suffered great and unremitting vaginal pain for a period of years. She related this pain to what she claimed was botched surgery (as well as repeated attempts at corrective surgical intervention). At one point she was committed to a mental hospital because no physical source could be found to explain the pain of which she complained. Eventually she decided that she didn't want to live with this psycho-somatic pain any longer and she sought out Kevorkian. A complete autopsy following her death failed to show *any* physical cause for her pain. (Tr. of February 15, 1992, at 338-339; App. 9-10) Moreover, there was *no* question that Mrs. Wantz was *not* terminally-ill, even under the broadest possible definition of that term.

The vast majority of the 44 individuals Kevorkian has assisted to commit suicide were not terminally ill as that phrase is commonly understood – that is, persons having less than six months to live. Many of the people he assists to die continue to be individuals who appear to have simply decided they don't want to live anymore.[6] Two individuals have died after suffering from non-terminal emphysema. One woman had arthritis and osteoporosis. A recent patient/victim was depressed, overweight, and allegedly suffering from "chronic fatigue syndrome" and fibromyalgia. Prior to death she had made allegations of

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decided that she wanted to die, she answered: "That's a tough question. I mean, I knew when I had MS, you know, I didn't want to be a burden to anybody, and if I couldn't function as a human being, I didn't want to live. So, it's been quite some time." (Tr. of January 8, 1991, *supra*, at 169; App. 8.)

[6] M. Betzold, *"Drop dead, Dr. K"*, The Detroit Sunday Journal, June 16, 1996, p 1, col. 3.

spousal abuse against her husband, allegations which she subsequently sought to disavow. If those allegations were true, they cast serious question on her reasons for seeking to end her life. If they were false, they cast serious question on her mental competence in seeking death.

Once again, it can be expected that supporters of assisted suicide will argue that simply imposing more safeguards, or checks and balances, can alleviate any of the concerns arising from Kevorkian's unregulated practices. Practical experience shows that such optimistic assessments must be rejected.

If a complex system of safeguards is to be set up to attempt to regulate assisted suicide, establishment of such a system is a job for state legislatures, not a judicial function. Moreover, once this Court pronounces a limited right to assisted suicide under certain conditions, it has cut off public debate and interfered with the ability of the states to legislate effectively.

Supporters of assisted suicide maintain that with sufficiently stringent criteria and proper monitoring, the State could ensure that only competent, terminally-ill adults would receive the "benefit" of physician assistance to end their lives. However, practical experience demonstrates that it is naive to believe that the practice of assisted suicide, once legitimated even in a limited form, could be successfully restricted or regulated.

Estimates seem to vary, but a clear majority of states currently outlaw assisted suicide. Yet the fact that it is criminally actionable in most states has not dissuaded numerous doctors and nurses from quietly practicing either assisted suicide or out-right euthanasia, as the writings and practice of Respondent Quill show. See generally, T. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* (1993). Some people therefore argue

that, since it's being done anyway, why not simply legalize it under strict regulations and thereby control it? However, given that assisted suicide and euthanasia are being conducted in secret despite criminal bans, why should anyone but the most starry-eyed optimist believe that legalizing the practice under detailed regulations would serve to *control* the practice?

In their article *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U Richmond L Rev 1 (1996), authors Daniel Callahan and Margot White respond to the assertion that establishing specific rules and codes of practice will serve to bring the practice into the open and to control it:

> * * * If it is truly the case that the present statutes forbidding euthanasia and PAS [physician-assisted suicide] are widely ignored by physicians, why should we expect new statutes to be taken with greater moral and legal seriousness? There is no available survey or other evidence to indicate that new laws will bring increased commitment to following the law. [*Id.* at 5.]

Kevorkian has written that he was inspired to action by his trip to the Netherlands to study their experience with assisted death. *Prescription: Medicide, supra*, at 189-192. The Dutch experience with legalized euthanasia demonstrates the futility of believing that legalizing the practice under strict controls could result in an orderly process applied only to those who met stringent guidelines. Once the government approves of the practice – even the very *limited* practice that some have advocated – there would simply be *no* way to contain it. It would be like saying that we could tolerate just a little bit of the Ebola virus in our bodies.

Dr. Richard Fenigsen, who has extensively studied the experience in the Netherlands, has written of the way in which the practice expands organically in spite of specific procedures which are mandated by the government. Fenigsen notes that the Dutch have one of the best and most comprehensive health care systems of any industrialized nations. Nevertheless, despite this comprehensive care system, "the lives of many people are deliberately put to an end, and this happens sometimes upon the request of the person in question and sometimes without his or her request, consent, or knowledge." R. Fenigsen, M.D., *Physician-Assisted Death in the Netherlands: Impact of Long-Term Care*, 11 Issues in Law & Medicine 283 (1995). Looking to data for the year 1990, Fenigsen reports that out of 13,506 lives ended by withdrawing or withholding medical treatment with the intent to terminate life, 8,750 (or 64.78%) occurred *without* the patient's consent. Similarly, out of 11,800 individuals whose lives were ended through active euthanasia, 5,941 (or 50.35%) occurred *without* the patient's consent. Fenigsen further notes:

> The Report of the Government Committee confirmed that the lives of newborn babies with disabilities and of gravely ill children are also terminated, but no exact figures pertaining to these groups were obtained. However, an estimate of euthanasia on newborn babies and infants up to three months after birth was published by the Royal Dutch Society of Medicine in 1988. Annually, three hundred babies disabled due to extreme prematurity, birth trauma, spina bifida, or Down syndrome are starved and dehydrated to death or denied lifesaving surgery; ten babies with disabilities receive lethal injections each year.

> A Committee of the Royal Dutch Society of Medicine stated that termination of life of a newborn is justified if the child almost certainly would have an unliveable life. * * * .
>
> There may be disagreements between the persons who decide, but if the doctor and the parents agree on euthanasia, the life of the child will be terminated.
>
> According to the Royal Society's Committee, when the life of a disabled newborn is terminated, this should be done by refraining from lifesaving medical interventions and depriving the child of food and water; only when this is done and the child does not die, a lethal injection is justified. Again, the practice in some cases departs from the official advice, and doctors proceed directly to administering the lethal injections. *Id.* at 285-286; footnotes omitted.

The experience Amicus has had with Kevorkian firmly supports the above observations. An example which perhaps best illustrates the naiveté of believing that strict regulations can prevent abuse is the case of Rebecca Lou Badger. Kevorkian allegedly assisted Badger to commit suicide on July 9, 1996. Badger had been diagnosed with multiple sclerosis. However, an autopsy revealed no evidence of the disease. Detroit Free Press, Oct. 31, 1996, at 1A , col. 1; see also, Detroit Free Press, Nov. 4, 1996, at 1B, col. 2. In interviews that Badger had with the Merced County [California] Sheriff's Department, she claimed that her mother was pressuring her to commit suicide and "had twice provided her with narcotics" for that purpose. *Id.* The October 31, 1996, Detroit Free Press article goes on to report at page 12A:

> Friends and relatives interviewed in recent weeks described Rebecca Badger as an unreliable woman who often lied. But whether or not

> her accusations against her mother are true, the events she described – some of which are confirmed by hospital records and police reports – reveal a disturbed and confused woman who vacillated between a desire to die and a fervent wish to live.

In response to such criticism, Kevorkian's attorney is reported to have responded to the Free Press reporter: "What's the point? I do not care if she thought Martians were coming after her." *Id.* Similarly, in an article titled "*Post Mortem*" in the September 16, 1996 issue of People Magazine at page 53, Kevorkian's attorney is reported to have asserted that Kevorkian merely relied on Badger's medical records when deciding that she was a suitable candidate for this service:

> "If they were wrong, then take the doctors' licenses away," [Geoffrey] Fieger fumes. "Don't criticize Jack. **He just accepted what they said**, and they said it repeatedly over the years." [*Id.* at 55; emphasis supplied.]

The article continues at page 55:

> • • • But the respected UCLA neurologist Dr. Louis Rosner, coauthor of the book *Multiple Sclerosis*, argues that since MS is often misdiagnosed, Kevorkian should have sought more opinions, "He accepts anything [patients] bring him as medical evidence," Rosner says, "and goes ahead with their wishes."

Badger's personal physician now says that she merely assumed Badger had MS because that was the diagnosis made by her neurologist. The neurologist now says that "his diagnosis was never conclusive" and that Badger could have suffered from Munchausen syndrome. Detroit Free Press, Nov. 4, 1996, *supra*, at 8B. It also appears that Badger was likely making continuing claims

of pain in an effort to obtain more pain relievers such as Vicodin, Demerol, and liquid morphine. *Id.*

According to the above article in People Magazine (and verified by a taped interview with Badger's daughter Christy Nichols, who was present when her mother died), Kevorkian's associate, Dr. Georges Reding interviewed Badger for between fifteen to thirty minutes immediately prior to the suicide itself to determine Badger's mental competence.[7] While Reding was conducting the *pro forma* interview, Kevorkian and his associate Neal Nicol were already setting up the apparatus and chemicals with which the deadly poisons would be introduced into Badger's body. See also Detroit Free Press, Nov. 4, 1996, *supra* at 8B.

Thus the case of Rebecca Badger tellingly reveals the way things will be if this Court recognizes a constitutional right to assisted suicide. Kevorkian followed the general outlines of the steps that most supporters of assisted suicide have argued would control the practice. He reviewed Badger's medical records. He interviewed Badger herself to determine if she was competent and if it

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[7] The involvement of Dr. Reding is clearly meant to stem criticism that has been leveled at Kevorkian based on the fact that he has no expertise in evaluating the mental status of his "patients." However, Dr. Reding is a vocal supporter of Kevorkian's campaign and cannot be expected to function as a neutral evaluator. As reported in the August 25, 1996, issue of the Dallas Morning News at p 1A, col. 1, Dr. Reding addressed a press gathering and stated: "I want to make sure that this word 'depression' is properly diagnosed and not mixed up with despair," Dr. Reding told the reporters. "People with a history of mental illness long before they become ill are one thing. But sick people despondent about their own suffering are another. In that case, their depression is rational and the antidote is not Prozac, but death."

was her considered choice to commit suicide. His associate, Dr. Reding, also interviewed Badger to assure that she was competent to make the decision to end her life. The key determination in their assessment was whether this was *her* considered choice. Since it was viewed from the perspective that the "patient's" right to personal autonomy was paramount, when Badger stated that she wanted to commit suicide, and she exhibited an objective basis grounded in her apparent medical condition for that decision, then Kevorkian and his associates merely acted to facilitate her assertion of her autonomous right.

Supporters generally speak in terms of *physician*-assisted suicide. Aside from the fact, as noted above, that this involves doctors in a realm that runs counter to their duty as healers, it elevates the practice of helping someone to kill themselves to a *medical procedure*. As Kevorkian's activities have clearly shown, assisting someone to kill themselves is *not* a medical procedure.[8]

Assisted suicide can be practiced in many forms. Kevorkian has utilized but two of the possible forms – carbon monoxide poisoning and injection of potassium chloride. The former can be administered by anyone – there is no need for a *doctor*.[9] Numerous *un*-assisted suicides occur each year from people who get into their cars in closed garages, start the engines, and drift off to death from carbon monoxide inhalation. Even injection of

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[8] In his testimony in the civil injunction case, Kevorkian acknowledged that his activities were not medically accepted and recognized procedures. Tr. of June 8, 1990, at 28; App. 1.

[9] Indeed, although still possessing a medical degree, Kevorkian's license to practice medicine has been suspended by both Michigan and California following his involvement in the Adkins death. This has not prevented him from continuing to assist others to commit suicide.

deadly drugs can be accomplished by other health professionals (such as nurses,[10] medical technologists, or physician assistants), by those who regularly self-inject medication (such as diabetics), or by virtually anyone who desires to study the technique and practice a little.

Furthermore, the right which doctors such as Respondent Timothy Quill have attempted to secure is the right to simply dispense oral prescription medicines to terminally-ill competent adults for them to utilize without active physician assistance to end their lives.[11] Such assistance may be provided by anyone licensed to dispense controlled substances. Once the right to die with assistance is recognized, how could it be limited to medical doctors when the procedure itself is not a medical procedure and no particular medical training is necessary in order to administer it?

Columnist Richard Cohen has written in his nationally-syndicated column (reprinted in the Detroit Free Press, June 30, 1996, at 3E, col. 1, *"Patient's can't tell their stories after their visits to Kevorkian"*):

> Why, I ask myself, can a woman be driven several hundred miles to see Dr. Jack Kevorkian but cannot be placed in the same car within her own closed garage and commit suicide within a step or two of her own home?
>
> The answer, I conclude, is not that the act of suicide is physically beyond her; it's rather that

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[10] See, D. Asch, M.D., *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New England J Med 1374 (1996), at pp 1374-1379 and C. Scanlon, R.N., *Euthanasia and Nursing Practice – Right Question, Wrong Answer*, 334 New England J Med 1401 (1996), at pp 1401-1402.

[11] In other words, an exception is sought with regard to stringent controls that are placed on a doctor's ability to prescribe and dispense controlled substances to the public.

she needs a facilitator. This is where Kevorkian comes in. The road to his clinic is a one-way street.

Kevorkian is a retired pathologist whose training and experience consists largely of examining corpses rather than in counseling live patients. He has no formal expertise in psychiatry or psychology. (Testimony of Jack Kevorkian, Tr. of June 8, 1990, 41-42; App. 2-3) Although he claims in his writings that he consulted with the personal physicians of his subjects, he sought no independent second opinions. In fact, he frequently ignored the opinions of those medical professionals who had been counseling, treating, or assisting the decedents.[12] He also ignored the physical evidence in front of him.[13]

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[12] As Kevorkian writes in *Prescription: Medicide*, *supra* at 222:

> I then telephoned Janet's [Adkins'] doctor in Seattle. He opposed her planned action and the concept of assisted suicide in general. **It was his firm opinion that Janet would remain mentally competent for at least one year (but from Ron's [Janet's husband's] narrative I concluded that her doctor's opinion was wrong and that time was of the essence).** Because Janet's condition was deteriorating and there was nothing else that might help arrest it, I decided to accept her as the first candidate – a qualified, justifiable candidate if not "ideal" – and well aware of the vulnerability to criticism of picayune and overly emotional critics. [Emphasis supplied.]

[13] In an op-ed column (W. Smith, *Depressed? Don't Go See Dr. Kevorkian*, N. Y. Times, Sept. 16, 1995, at § 1, p. 19, col. 2), Wesley J. Smith quotes Dr. Randolph B. Schiffer, an advisor to the National Multiple Sclerosis Society, as follows:

Kevorkian is answerable only to himself. Not only does he ignore the law, he taunts and belittles those who would enforce it against him. The Michigan Court of Appeals and the Michigan Supreme Court have upheld both a temporary state statute forbidding assistance in a suicide and the continued validity of the State's common-law prohibition against assisting a suicide. *People v Kevorkian*, 447 Mich. 436; 527 N.W.2d 714 (1994), cert. den. ___ U.S. ___; 115 S. Ct. 1795; 131 L. Ed. 2d 723 (1995); *People v Kevorkian No 1*, 205 Mich. App. 180; 534 N.W.2d 172 (1994). Nevertheless, Kevorkian has not only convinced three juries to ignore the law,[14] he has continued

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> "If a patient with multiple sclerosis has bed sores, it means by definition that, for whatever reason, he or she is not receiving adequate medical care."

Smith goes on to observe:

> Last month, Esther Cohan, who was 46 years old, committed suicide with the help of Jack Kevorkian. Ms. Cohan, who had multiple sclerosis, was disabled but not terminally ill. Esther's sister told reporters that her sister's body was covered with bed sores. Yet, according to Jack Kevorkian's lawyer, Geoffrey Feiger, Dr. Kevorkian had been "counseling" Ms. Cohan since March. Didn't he know that he was participating in the suicide of someone who, by Dr. Schiffer's standards, appears to have received inadequate care?

[14] Professor Yale Kamisar of the University of Michigan has noted the increased incidence of jury nullification associated with cases involving "mercy killing" in the 1940's and 1950's. Y. Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 Minn L Rev 969, 971-973 (1958). His observations have been proven to apply equally to physician-assisted suicide. Kevorkian has been tried three times (once in Wayne County, Michigan, and twice in Oakland County, Michigan, involving a total of five patients/victims) and has

to violate the law and publicly boast of his transgressions.

Practical legal problems beyond the specter of jury nullification have already arisen in this area, as the experience of amicus has shown. Kevorkian initially announced his participation in the assisted suicides of his "patients." He would personally alert the police to the deaths. He was present when the police arrived and made statements to them. Evidence associated with the administration of the poisons (i.e., intravenous solutions, tubing, needles, carbon monoxide canisters, regulators, tubing, masks) was still present at the scene. Subsequently, when criminal charges were filed, he changed his practice. First, he would still contact the police, but when they arrived at the location of the suicide (often his Royal Oak apartment), the evidence associated with the suicide would have been removed. While he would make no statements to the police, his attorneys would subsequently call press conferences to announce Kevorkian's "attendance" at a suicide and to give details (often incorrect) of the deceased's medical background. Lately, Kevorkian has taken to simply dropping the body off at the medical examiner's office or at a local hospital, providing a few sketchy personal details about the deceased, and then leaving.

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been acquitted by the juries in each case. In each case there was clear and abundant evidence that Kevorkian actively assisted the decedents to commit suicide by providing the poison and the poison-dispensing apparatus and by hooking the decedents up to the apparatus. The defense did not dispute that he had done so. Nevertheless, in each instance the jury has seen fit to respond to Kevorkian's claim that he did not intend that the decedents should die, but rather that he only wished to relieve their pain and suffering.

Thus, Kevorkian continues to ignore the law while making it practically impossible to investigate or prosecute him. Since no one outside the immediate circle of participants knows for certain where the deaths occur, venue is difficult to establish.[15] Since the bodies are dropped off at the medical examiner's office or at hospitals, none of the paraphernalia associated with the "suicide" can be examined or seized. Those who are present at the death are either not identified, or, if their names are mentioned at a Kevorkian press conference, they refuse to cooperate with investigations by law enforcement.[16] In

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[15] Kevorkian's flamboyant attorney used this fact as a legal stratagem in a case tried in Wayne County. The body of Thomas W. Hyde, Jr. was found in Defendant's battered VW bus on Belle Isle, an island park in the Detroit River located in Wayne County. At trial, Kevorkian's attorney insisted that the death itself had actually occurred in Royal Oak – Oakland County, Michigan – and argued to the jury that they couldn't convict because venue (a necessary element) hadn't been established in Wayne County.

[16] An article appearing in the September 20, 1996 edition of the Detroit Free Press described how evidence obtained when police interrupted a Kevorkian "consultation" appeared to indicate that Kevorkian had assisted a 54-year-old Ionia, Michigan, woman who had multiple sclerosis to commit suicide. According to the article, a videotape seized by police depicts Kevorkian telling "an Ionia man how to mislead authorities about the cause of his wife's death". When questioned about this, Kevorkian's attorney responded: "I would urge all the families involved to tell the police that their loved ones went to Disneyland and fell off the mouse ride." A family physician had filled out the death certificate and attributed the death to natural causes resulting from multiple sclerosis. The body was then cremated. However, evidence of the woman's pre-death condition clearly suggested that she was not in a terminal condition. Detroit Free Press, Sept. 20, 1996, at 1A, col 2. Kevorkian's attorney has announced that there are others in

fact, when the police have subsequently contacted these individuals, they have refused to cooperate and referred the police to Kevorkian's attorney. The police and prosecutors have no way of compelling those witnesses to give information if they do not want to cooperate. Kevorkian's attorneys have routinely claimed to represent all the witnesses and have asserted their Fifth Amendment right not to incriminate themselves. Thus the public is left only with the self-serving statements of Kevorkian's attorneys describing what has occurred and the medical condition of the patient before his or her death.

Another legal obstacle to any effective regulation of assisted suicide is the venerated legal principle that mere presence at the scene of the crime is not itself a crime. *People v Burrel*, 253 Mich. 321, 323; 235 N.W. 170 (1931). That is why Kevorkian can stand in front of television cameras and state with impunity, "I was present at another assisted suicide." In that way Kevorkian takes credit for thumbing his nose at the law with no real risk to himself. Moreover, any comments his attorney makes cannot be used as evidence against Kevorkian.

If a right to physician-assisted suicide is recognized, regardless of how limited the right or how carefully we craft guidelines to prevent abuses, experience shows us there is no effective way to insure compliance with those guidelines and guarantee that significant abuses will not occur.

Michigan who have received Kevorkian's assistance in ending their lives, but whose names have not been, and will not be, released. *Id.* at 8A, col. 1 and Detroit Free Press, Sept. 12, 1996, 8B, col 1. On November 4, 1996, Kevorkian finally admitted that he had been present in Ionia at the death of Loretta Peabody. Detroit Free Press, Nov. 5, 1996, 1B, col. 2.

Police investigations into suspicious cases will be hindered by invocation of the physician-patient privilege.[17] The physician and patient's family control all of the information. Assisted suicide, by its nature, is a private matter between physician and patient. Decisions about suicide are made in private and the action itself is taken in private. Since we cannot place a police officer in every doctor's office, there is no practical way of knowing what the doctor and patient are going to do or what they have done. After death there is no practical way to determine whether the decision to commit suicide was voluntarily made, without subtle pressure or manipulation. A "conspiracy of silence" will develop since the "patient" will be dead and the physician will be able to invoke the privilege as a means of avoiding any questioning. Callahan and White, *supra*, at 8.

Furthermore, the physician-patient privilege would prevent law enforcement personnel from knowing the patient's plans for death or from obtaining medical records to determine the true medical condition of the patient. The physician-patient privilege continues after death and thus, even after the suicide has occurred, there is no way in which the truth of the suicide's condition can be determined. Practical experience in Michigan has

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[17] While acknowledging in his in-court testimony on June 8, 1990, that his use of the "suicide machine" with Janet Adkins was not a medically recognized and accepted procedure [Tr. of June 8, 1990, at p 28; App. 1], he claimed in his deposition testimony that his interview with Adkins was privileged because it was a medical consultation between a patient and her physician. [Tr. of July 25, 1990, at 8-9; App. 4-5.] Kevorkian's attorneys subsequently raised the physician-patient privilege as a barrier to turning over routine discovery during Kevorkian's criminal trials.

shown that this concern is very justified. As noted, Kevorkian has counseled "patients" and their families and friends to decline to cooperate with police investigations. See fn 16, *supra*. He has also apparently participated in one or more assisted suicides which have been covered up.

And what of the mental competency of the individuals who have surrendered themselves to Kevorkian's "tender ministrations"? Case law recognizes that one of the main reasons suicide itself was de-criminalized is that people who desired to commit suicide were generally considered to be mentally disturbed. T. Marzen, M. O'Dowd, D. Crone, & T. Balch, *Suicide: A Constitutional Right?*, 21 Duquesne L Rev 1, 63, 69 and n 467, 85-86, 88-89 (1985); *In re Joseph G*, 34 Cal. 3d 429, 433; 667 P.2d 1176; 194 Cal. Rptr. 163 (1983). As noted previously, Kevorkian's second "patient", Marjorie Wantz, had previously been committed to a mental hospital. Judith Curren was despondent over her weight, her "chronic fatigue syndrome", and, perhaps, her marital situation. Rebecca Badger had a history of alcoholism, an apparent addiction to pain medication, vacillated on the question of whether she wanted to die or whether she was being pressured to do so by her mother, and is now said by her neurologist to have possibly suffered from Munchausen's syndrome. Kevorkian's response is that the mental condition is irrelevant as long as the "patient" has some physical malady and knowingly requests his assistance to die. Tr. of June 8, 1990, at 40, 44-45; App. 3-4.

More significantly with respect to most potential "patients," however, is the fact that studies have shown that most individuals who express interest in committing suicide are suffering from depression – often arising out

of their condition or the absence of a support system – and that when the depression is treated, the desire to commit suicide disappears. See, *e.g.*, Report of the New York State Task Force On Life And The Law, Executive Summary, p x.[18]

In an article titled, *"Mock Medicine, Mock Law"* in the June/July 1996 issue of the journal First Things, Dr. Eric M. Chevlen, the Director of Palliative Care at St. Elizabeth Health Center in Youngstown, Ohio, (and a prosecution witness in both of the Oakland County criminal trials) has written of watching a Kevorkian-produced videotape of an interview with a "patient":

> The videotape seemed to be filmed in a cheap hotel room. It showed a man with advanced myeloma (bone cancer) asking for assistance in suicide. He appeared to be a textbook example of depression in the face of medical illness and inadequately treated pain: the flat voice, the lack of eye contact, the moving description of how life no longer yielded any pleasure, and even the veiled contempt he expressed for his own disability. I have seen many such patients in my career. In every case, the request for suicide was a symptom of depression, a treatable complication of cancer. In every case, proper treatment of the patient's pain, accompanied by emotional support and occasionally antidepressants resulted in reversal

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[18] The Report summarizes: "Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal. Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide."

of the wish to be killed. As I watched the interview, I felt like shouting at the eerily jovial "doctor" on the screen, "He's depressed, you idiot! Treat him, don't kill him!"

But of course I knew that only a few hours after the videotape was made the myeloma patient had joined the long list of those who had died "in the presence of" Jack Kevorkian.

The encounter between Kevorkian and his victim was a simulacrum of a genuine medical interview. When Kevorkian asked the victim whether or not he had been experiencing pain, it was not with the intent to find a better medicine to treat it. It was to justify the use of the carbon monoxide he had obtained even before meeting him. When Kevorkian asked about the victim's anguish and wish to die, it was not to assess or relieve the obvious depression. It was to document that his "assistance" was given only with the victim's consent. [*Id.* at 17.]

Additionally, in light of the delays that have occurred while the issue of assisted suicide was appealed in the Michigan courts, in light of the successful public relations campaign Kevorkian has conducted, in light of the inability of law enforcement to either stop the practice, issue charges in pending open investigations, or to secure convictions following three separate trials, public opinion and blatant defense appeals to jury nullification have made it increasingly difficult or impossible to obtain a jury that will follow the law.

In fact, given that judges in Michigan are elected, it is not surprising that many judges facing re-election (and with an eye on the public opinion polls) find it difficult to divorce their personal opinions on the issue from their legal duty to follow the law. This reality will work to discourage active investigation by the police or serious

efforts to prosecute by the local prosecutors. Already the candidates for Oakland County Prosecutor from both political parties have publicly indicated that they will not prosecute Kevorkian under the Michigan common-law prohibition recognized by the Michigan Supreme Court, and have further indicated reluctance to institute any prosecutions even if the Michigan Legislature enacts a specific statutory prohibition.

In *Legalization of Physician-Assisted Suicide, supra,* at 5-6, Callahan and White observe:

> * * * Nor are there any surveys or other available evidence to suggest that prosecutors will show more zeal with new laws than with the old ones, or that juries will display less sympathy for violation of the new rules than they have for those who transgressed the old rules. It is, in short, very odd to claim that physicians who now do as they please, with complete de facto immunity from prosecution, will act differently with new laws, and that the new laws will be more stringently enforced. [Footnote omitted.]

A strong and clear judicial response that unequivocally states that the Constitution does not contain a right to assisted suicide would go far toward influencing public attitudes and putting the lie to the claim voiced by Kevorkian and his supporters that he is only doing that which is protected by the Constitution. It would alleviate the confusion which has arisen as a result of the conflict between the decisions of the Ninth and Second Circuits striking down bans on assisted suicide and the decisions of state courts which have upheld such bans. It would also place this serious and troubling issue into the proper forum – the state legislatures where the people's elected representatives can debate and grapple with a solution, or the ballot initiative alternative where the people can

directly vote on the issue. It is only by refusing to recognize a new and uncontrollable constitutional right to have the assistance of another person to commit suicide that this Honorable Court can ultimately protect the rights of those who would inevitably become victims of the seductive "right to die."

CONCLUSION

WHEREFORE, Amicus Richard Thompson, Prosecuting Attorney in and for the County of Oakland, respectfully requests this Honorable Court to reverse the decisions of the Ninth and Second Circuits in *Washington v Glucksberg*, 79 F.3d 709 (CA 9, 1996) and *Vacco v Quill*, 80 F.3d 716 (CA 2, 1996).

Respectfully submitted,

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APPENDIX

Excerpts from testimony of Jack Kevorkian in Oakland County Circuit Court in case no. 90-390963 AZ, June 8, 1990

Page 28:

Q [By Ass't Prosecutor] Doctor, would you say your use of the machine with Janet Adkins was in fact a medically accepted and recognized procedure?

A [By Jack Kevorkian] Not at all.

Q You in fact admit that it is not?

A It is not an acceptable practice; that's obvious.

Pages 40-41:

Q [By Ass't Prosecutor] And yet you're saying that you have to decide whether someone is worthy of your machine or not, so –

A Based on my medical expertise, not morality. My morality doesn't enter this. You don't know what my morality is. You haven't asked me that. But my medical expertise is the basis. There are five – may I go on with this and explain it briefly? There are five – I've come to this conclusion. I must – understand that it's not egotistical when I say, "I've done this, I've done that." Nobody helps me. I've got to do it. There are five criteria. Two with the patient: the patient's needs and the patient's wishes. Two. You take these into consideration. From the doctor: His medical expertise; his common sense; and his logic. Three. Now, these last

two are lacking in many doctors. Common sense and logic. The expertise he has. Everyone has that. We know that. They're pretty much equal.

Now, a good doctor would put these all together, and his expertise is the cardinal point. That's why ethicists don't belong in this decision. The doctor can philosophize as well as any theologian can, but a theologian can't know medicine like a doctor. It takes training and experience.

So, based on these five criteria – I wish it could be a group of doctors pooling this, without any extraneous ethicists – he comes to a decision with the cardinal point being medical expertise. Is the patient's wish and desire worthy of having this option granted?

Pages 41-42:

THE COURT: Excuse me, Doctor, but what is you medical expertise?

THE WITNESS [Jack Kevorkian]: Mine is limited, and that's why I say I want to pool, but they won't come forward –

THE COURT: No, no –

THE WITNESS: A pathologist, certified pathologist.

THE COURT: Are you licensed to practice pathology –

THE WITNESS: Licensed in Michigan and California – in California and Michigan, licensed to practice, yes, your Honor.

THE COURT: Do you have any other licensures in some –

THE WITNESS: No, just those two states.

THE COURT: Just those two states, both for pathology only.

THE WITNESS: No, for medical doctor. I could open an office if I want. I could help with surgery. I could treat any disease I want. Medical licensure allows one to do anything in medicine.

THE COURT: But you said expertise. Are you –

THE WITNESS: My specialty expertise is pathology, right.

Pages 43-44:

Q [By Ass't Prosecutor] Well, Doctor, don't you think that suicidal ideation would be an important thing that you would have to know before you deal with people who are asking to be put to death?

A Not if they have a crippling physical disease. Suicidal ideation is a mental problem. I don't rely on mental problems. I rely on their physical disease, which then affects their mind. Anybody who's got a terrible crippling disease or terminal cancer and is not depressed is abnormal.

Pages 44-45:

Q [By Ass't Prosecutor] Doctor, so in other words, you really don't care what the person's mental state is, if they in fact have a crippling disease and they say they want to die?

A Well, of course, I care. But the cardinal point is the physical disease. Is a physical disease enough to account for the mental state of the

patient? I said it's a grey zone. But in the case of David Rivlin last year, everybody who saw him said he should die, except a couple of religious fanatics. Now, would it take a great amount of medical expertise to decide that? If nothing else, establish this policy for that kind of case where everybody who looks at it says, "Yes." Even if it doesn't take a doctor.

Excerpts from Deposition of Jack Kevorkian in Oakland County Circuit Court case no. 90-390963 AZ, July 25, 1990

Pages 7-9

Q [By Ass't Prosecutor] As I understand it, when the state police officers contacted you as to being able to see a videotape they understood was available with your meeting of Mrs. Adkins on June 2nd –

A [By Jack Kevorkian] Uh-huh.

Q – you indicated you would not let them see it. Is that correct?

A That's true.

Q And you indicated there was going to be certain ground rules as to who could see that tape?

A Yes, but I didn't spell out the ground rules in detail.

Q Weren't they, in fact, the same ground rules that were in line with the consent to videotape that Janet Adkins prepared?

A That was part of it.

Q So, in other words, in this form where it states, (Reading) " . . . that said videotape or

motion picture be made available on a non-profit basis for viewing only by professional medical personnel, legislators, and judicial and other duly empowered authorities directly concerned with the promulgation and creation of the laws, rules, regulations, and ethical guidelines in connection with doctor-assisted suicide, with active euthanasia, or with judicial execution involving some kind of direct medical action and/or pharmaceutical drug."

Are you saying there were others?

A Yes, at that time I should have, I should have remembered – this was a medical consultation. It's privileged.

Q I'm sorry, where does it say that?

A It should have said that. That's an oversight.

Q And it doesn't say that?

A That's right.

Q If you're going –

A I realized later it's medical privilege between a patient and doctor.

Q When did you realize that?

A Later.

Q When's later.

A I cannot recall, but it was after this.

Page 13:

Q [By Ass't Prosecutor] Okay. And at this point in time had you, in fact, been retained as her doctor?

A [By Jack Kevorkian] When she contacted me I was retained as her doctor, yes.

Q When did they contact you?

A Her husband actually contacted me for her and she, I assume, she became my patient when I met her on June two.

Q That's the first time you had any contact with her?

A That's the first time I had direct contact with her personally.

Page 18:

Q [By Ass't Prosecutor] Okay. How long was the videotape?

A [By Jack Kevorkian] It's about 40 minutes.

Q And how was it finally concluded?

A I had come, I concluded that there was enough evidence that she was mentally sound. She knew what she was doing.

Pages 24-25

Q [By Ass't Prosecutor] At the time prior to the videotaping, did you physically examine Janet Adkins?

A [By Jack Kevorkian] No.

Q Did you take her heart rate?

A No.

Q Listened to her heart?

A No.

Q Did you even bring a stethoscope?

A No.

Q No physical evaluation at all?

A No.

Q Why is that?

A Her doctors had done all that. I had the records. Also it's a mental disease, not physical.

Q The records, as I understand it, were from the previous year; isn't that correct?

A It's a mental disease, not physical. You all know it's not physical. It's an attack that's being used for a criticism of what I did.

Page 27:

Q [By Ass't Prosecutor] What if she was suffering from depression?

A Not to be depressed with Alzheimer's is abnormal.

Q Okay. The fact that a depression might have caused her to want to possibly commit suicide, wouldn't matter to you?

A A person can be rational and depressed and can make a rational decision.

Excerpts from testimony of Sherry Miller in Oakland County Circuit Court, case no. 90-390963 AZ, January 8, 1991

Page 155:

Q [By Kevorkian's attorney] Don't you have a responsibility to your parents to allow them to continue to take care of you?

A [By Sherry Miller] No, I'm going to say – yeah, I don't think that's fair because I have to burden my parents with the responsibility of taking care of me. Forty-two years old. They're getting older. No, it's not fair.

Page 169:

Q [By Ass't Prosecutor] Now, when is it that you first decided that you wanted to die?

A That's a tough question. I mean, I knew when I had MS, you know, I didn't want to be a burden to anybody, and if I couldn't function as a human being, I didn't want to live. So, it's been quite some time.

Excerpts from preliminary examination testimony of Dr. Ljubisa J. Dragovic in 52/3 District Court, case no. 92-115190 FC, February 15, 1992

Pages 326-327:

Q [By Ass't Prosecutor] Okay. Was Sherry Miller in danger of imminent death as a result of this multiple sclerosis?

A [By Dr. Dragovic] No.

Q Had it had any effect on her heart?

A No.

Q Her lungs?

A No.

Q Her gastrointestinal system?

A No.

Q Given the fact of her physical condition, and the condition of her heart and lungs and the

rest of her body, could you project a period of time where she would continue to live and not be in danger of death?

A That's for the Almighty to decide, really, in every one of us. But based on the evidence that was present, the examination of – her internal examination – there was no suggestion that she was in any acute phase of the disease that would have threatened her life in a matter of days or even weeks, for that matter.

For comparison – and it might sound parodoxical, she was talking about whether she was quote/unquote, terminal, she was no more terminal than, let's say Magic Johnson.

Pages 338-339:

Q [By Ass't Prosecutor] Did you examine the tissue to where would there be any sort of unremitting pain for Mrs. Wantz?

A [By Dr. Dragovic] I did not find any anatomical evidence that would have suggested itself as a source of pain there, in the genito urinary system, nor in the gastro intestinal system, for that matter.

Q Did you take any further steps to determine any source of pain there?

A All that I examined, including the sacral dorsal root ganglia that I removed together with the spinal cord, did not show evidence of structural abnormality.

Q If there's no structural source for the pain, and a person was feeling pain, Doctor, where would that pain be coming from?

A Without evidence of source of pain in that area, then pain would be generally central in character and origin.

Q What is central pain, please?

A Central pain means arising in the central nervous system, arising in the cortex of the central nervous system.

Q What does that mean in layman's terms?

A Layman's terms, would be – it would be pain coming from someone's head, not pain coming from a particular organ.

Q Is that a common phenomena?

A It's not unheard of in people that have this kind of problem.
